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Does the Place Where We Are Born Matter?

Until the middle of the twentieth century, most births in rural Ireland took place in the home. From then on, childbirth increasingly took place in hospital settings. Not only did this physical relocation of birth from home to hospital affect women's lived experiences of childbirth and traditional midwifery practices, but both were also inextricably bound up with the complex relationship to women's bodies and place within the evolving postcolonial Irish state.

This article is an historical overview of the uprooting of birth from home to hospital in Ireland. It documents the main policy changes that led to the current obstetric-led, institutionally based maternity system. It highlights how this postcolonial state effectively erased traditional midwifery practices and eventually removed midwifery services from local communities. The subsequent centralization of maternity services led to a huge reduction in maternity units from 108 in 1973 to nineteen today; consequently, there is a very limited obstetrically driven maternity service, which is almost entirely hospital based.

This research is part of my PhD, which is an interdisciplinary art practice-as-research project that uses methodologies employed by feminist ecocritical thinkers, new materialists, cultural geographers, and socially engaged art practitioners; it incorporates oral testimonies, archival material, film, drawings, paintings, and found objects. This complex layered reading of the interrelationships between place, birth, and memory will contribute to a shared knowledge, placing it at the intersection of international research in medical humanities and collaborative, participatory socially engaged arts practices.

“Imagining human corporeality as trans-corporeality, in which the human is always intermeshed with the more-than-human world, underlines the extent to which the substance of the human is ultimately inseparable from ‘the environment.’”—Stacy Alaimo 2

Introduction

Tracing the historical trajectory of birth in Ireland from local communities to institutional settings has largely drawn on social and historical contextual readings (Delay; Clear; Gelis, Kennedy; Devane et al.; Murphy-Lawless; O'Boyle). However, what of the spectral traces embedded within the places associated with childbirth? A different understanding of birth practices emerges from a rereading of the history of the place where birth happens; thus, it is possible to reemphasize the importance of community and environment in connection with the birthing body.

The politics of birth space in Ireland that led to the shift from home to hospital birth is immersed in a long colonial and postcolonial history of place and women's bodies (Cronin; Howe; Lloyd). The current maternity system is inextricably bound up with legacies associated with church, state, and medical interpretations of the birthing body, which are reflected in the current policies and places where birth takes place (Earner-Byrne; Kennedy; O'Connor; Murphy-Lawless).

In mapping places of birth in Ireland, and County Clare in particular, I explore how the entanglements of place, birth, and memory have changed over time and consider how the lived experience of being born and of giving birth has been affected by the transition from home to hospital birth, focusing on those living in rural Ireland (Biggs; Rose; Hawkins and Straughan; Lacy; Reckitt). My work documents this move and charts the shifting perceptions and experiences of place during labour and childbirth.

The main reason for concentrating my research on County Clare is because there are no maternity services in this area. The last maternity unit there closed in 1987, since that time, women have had to travel to either Limerick or Galway for all appointments during their pregnancy and when in labour. This can mean journeys of up to two hours each way, which is one of the changes resulting from a series of health policy changes. Intergenerational oral testimonies, primarily with women who have given birth while living in County Clare from the 1950s onwards form the crucial primary source material and inform this research as it progresses.

Theoretical Framework for This Research

Feminist theorists in conjunction with new materialist thinkers allows for a reimagining of the historical legacy of midwifery and maternity services in Ireland—one that offers a different understanding of the relationship between the current obstetric-led, institutionally based maternity services (Alaimo; Bennett; Barad, Braidotti; Coole and Samantha; Dolphijn). The work of new materialist theorists, such as Stacy Alaimo and her theory of transcorporeality,

situates the event of childbirth within a complex exchange between the body, place, and matter. In the opening quote, Alaimo suggests that “‘the environment’ is not located somewhere out there, but is always the very substance of ourselves” (5). The entanglement of the birthing body with the place where birth takes place aligns with Alaimo’s theorisation of transcorporeality.

Sociologist Barbara Katz Rothman looks at the birthplace from a different perspective. She points out that “the location of birth is one of the hotly contested issues of contemporary motherhood” and that “birth means very different things in different locations; it is not simply the same event in a different space. A politics of space underlies ideology and practice” (87). Yet another way of interpreting place in relation to birth can be found in the influential text *The Poetics of Space*, by French philosopher Gaston Bachelard, which asserts that “the house we were born in is physically inscribed in us. It is a group of organic habits” (36). For Bachelard, the materiality of place is imprinted on us emotionally, psychically, as well as bodily. If this is so, then how has the change from home to hospital birth affected both our relationship with place and the lived experience of giving birth?

Another perspective on the significance of birthplace in Ireland has been expressed by curator Mary Grehan. In 1994, The National Maternity Hospital in Dublin hosted a centenary art exhibition curated by Grehan. Reflecting on this experience Grehan acknowledges that “we are born into places” and that this “can determine a number of socio-economic and cultural factors in our lives” (51).

Each of the theorists and thinkers referred to above bring a different perspective to the intersection of place with birth. In the context of the evolution of the maternity services in Ireland, the entanglement between place and birth is complex.

A Historical Overview of the Hospital Development Program in Ireland

In 1971, Erskine Childers, the minister of health, noted that “We have the highest proportion of hospital beds to population in Western Europe” (Daly 2). When the minister made this comment, hospital development in Ireland was at a critical juncture. The evolution of the hospital system, and specifically maternity services in Ireland, contributed to the formation of the current obstetric-led system dominating maternity services. The role of hospitals is bound up with the history of the evolving postcolonial Irish state during the twentieth century. Architectural historian Gary Boyd and architect John McLaughlin consider the significance that modernism played during the infrastructural growth in Ireland during the twentieth century:

The absorption of modernity in twentieth-century Ireland was characterised and experienced not by heavy industrial development, the mass production of housing and the emergence of a fully-fledged Welfare State—as for example in Britain—but rather a dispersed and decentralised modernism that was effected at different but no less pervasive scales and intensities ... the sites of architecture here were as much invisible systems as physical places in Ireland. (5)

For Boyd and McLaughlin, Ireland's decentralized architectural growth generated both visible and invisible networks and systems, including maternity hospitals and units around the country.

The expansion of the hospital system from the 1930s onwards contributed to a normalization of hospitalization for many illnesses. Historian Mary Daly notes that this period saw the development of “a hospital system, not a health system” (1). In the early 1970s, the average time spent in the National Maternity Hospital was 8.9 days, and in Waterford Maternity Hospital, it was 12.9 days (Daly 3). It became the norm for a woman to spend approximately ten days in hospital after giving birth—an experience many relished, as it gave them time away from family duties (Clear).

Health Policies affecting the Irish Maternity Services, 1950s to 1970s

Sociologist Patricia Kennedy highlights that in 1955, just over 33 per cent of all births in Ireland took place in the home. By 1970, home births made up 2.92 per cent of all births (11). In 2016, less than 1 per cent of births took place in the home (Meaney et al. 11).

There were several key policy changes that took place in Ireland between 1950 and 1970 that affected a woman's choice of where she could birth. Dr. Noel Browne was the minister for health in Ireland from 1948 to 1951. His name is synonymous with the Mother and Child Scheme (1950), in which he proposes that mothers and children up to the age of sixteen should have free medical care: “As a doctor, I believed that a free health service was an essential pre-requisite to an effective and a just health service” (159). This scheme was condemned by both the Church and the medical professionals. The former feared that it would lead to education surrounding childbirth and possibly abortion and contraceptive services being established in the country that was contrary to their social teaching policy (Fahey). The latter feared that it would lead to state control of the medical profession—a form of socialized medicine that would potentially affect their income and, more importantly, make them answerable to the state.

Browne's motivation for promoting the Mother and Child Scheme went hand in glove with his vision of creating more hospital services for the people of Ireland. Having worked in the National Health Services system in England,

he felt that Ireland deserved its own healthcare system, one capable of providing healthcare for a population beleaguered with poverty. As part of the national hospital building program, women were encouraged to give birth in hospital settings. There was a growing belief that hospital was the best and safest place to give birth, and given the levels of poverty in the country in the early 1950s, there is a strong case to be made for this assertion. For example, the infant mortality rates in Dublin were very high, whereas counties, such as Roscommon, had much lower infant mortality rates (Breathnach and Gurrin).

The Catholic hierarchy's vehement disapproval of the Mother and Child Scheme reveals three key points. First, families should pay for their healthcare; second, the social teaching provided by the Catholic Church on sex education was to be the source of knowledge women and their families were given, and, third, they did not want doctors from other faiths or nonfaiths attending women during pregnancy. The informal Church-state alliance was powerful and pervasive (Powell). Browne concluded that "the Church thrived on mass illiteracy and that the welfare and care in the bodily sense of the bulk of our people was a secondary consideration to the need to maintain the religious orders in the health service" (141).

The growth in the number of hospitals around the country as part of the development of the health service in Ireland during the 1950s normalized hospital births. From the late 1960s onwards, the centralization of maternity services led to the reduction of the number of maternity units from 108 in 1973 to nineteen in 2019 (O'Connor, "Maternity Closures"; "Maternity Care"). Centralization was proposed in two reports: the 1968 Fitzgerald Report and the 1976 Discussion Document (Development of Hospital Maternity Services). Both recommended that all women should give birth in obstetric-staffed units, a system that continues to this day (O'Connor, "Maternity Closures"; Murphy-Lawless).

The 1970 Health Act led to the creation of Comhairle na n-Ospidéal (the Hospital's Council), which oversaw the implementation of the 1968 Fitzgerald Report and the 1976 Discussion Document (Development of Hospital Maternity Services), as well as to policies that led to the closure of smaller maternity units around the country (Murphy-Lawless).

A further crucial policy ensuring that women give birth in the hospital setting was the introduction, and continued use, of the Active Management of Labour (AML), which was initiated in the early 1960s at the National Maternity Hospital, Dublin (O'Driscoll et al.; Murphy-Lawless). Its main objective is to manage the length of a woman's labour and to supervise it if prolonged. The definition of prolonged labour has dropped from thirty-six hours in 1963 to twelve hours in 1972 ("May I Break Your Waters?"). This drop highlights the focus and privileging of time over place, which is at the core of the AML system.

Exponents of this system believe that birth can be controlled by regulating the length of time that a woman is in labour through the use of medication and interventions. However, this form of control lies in the hands largely of obstetricians and not the birthing woman. AML controls the duration of labour, and when this is combined with other policy changes—such as the fact that each maternity hospital has to have minimum production levels of two thousand births a year, based on a bed occupancy of “three women per labour ward bed per 24 hours” (O’Connor, “Maternity Closures”)—one can begin to see how policies that focus on time have come to dominate the system.

These policies persist within the maternity services today in Ireland. Homebirth midwife and activist, Philomena Canning, spoke at The Convention on the Elimination of all Forms of Discrimination against Women, (CEDAW), the United Nations’ Women’s Committee, in Geneva in February 2017. In 2019, writing Philomena Canning’s obituary, Marie O’Connor said at the event, Canning argued the following:

“Active management” is premised on the denial of women’s human rights, viz., self-determination, bodily integrity and personal autonomy. In its quasi-judicial concluding observations, CEDAW expressed concern at Ireland’s reported policy ‘of having three births per 24 hours for every bed in maternity wards’, and called on the State to respect the natural birth process. (“Obituary of Philomena Canning”)

Uprooting Birth

Behind these data lies multilayered social, political, and cultural readings of women’s birthing bodies by the state, church, and medical professionals. The current maternity system in Ireland is the living embodiment of these changes, and women have had to adjust their experience and expectations accordingly.

One key element that has been part of these adjustments is the relationship with place. The rupture from home-place to hospital-space birthing experiences necessitates uprooting women during labour. The result of these changes means that women have little choice about where they can give birth. One of the consequences of the changes to this obstetrically driven maternity model and the huge reduction in maternity units is that women are expected to travel greater distances during pregnancy and labour than in the past. Currently, when a woman is in labour, she has the additional consideration of not just leaving her home but also of leaving her locality to give birth.

One further crucial change that directly affects where a woman can give birth came with the changing role of the midwife. The regulation of midwifery in Ireland has effectively removed midwives from local communities and

embedded them within institutional obstetric-led maternity services. Therefore, not only did the physical relocation of birth from home to hospital affect women's experiences of childbirth, it also directly affected traditional midwifery practices. Both were inextricably bound up with the complex relationship to women's bodies and place within the evolving Irish state.

Historian Ciara Breathnach acknowledges that the role of the traditional midwife had survived well into the twentieth century, particularly in rural areas, as "handywomen were deeply embedded in rural communities and difficult to uproot" (34). In her book, *The Need for Roots*, philosopher Simone Weill asserts that "To be rooted is perhaps the most important and least recognized need of the human soul" (43). Conversely, the uprooting of midwives from local communities in Ireland ignores the need for the roots that Weill identifies.

The extent to which this uprooting has taken place is exemplified by recent conferences organized to celebrate the regulation of midwifery, and 2018 was the centenary of the Midwives Act in Ireland, which saw the establishment of the regulatory authority, the Central Midwives Board, that oversaw the regulation of midwifery practices (Barrington 79). The first of the conferences was held on 1 October, 2018, at the Rotunda Maternity Hospital, Dublin. The second was on 22 November, 2018, hosted by the Nursing and Midwifery Board of Ireland, and it took place in the Thomas Prior Hall, former mason orphan girls school and now a hotel.

I attended the above conferences, and Simon Harris, the minister of health, spoke at both, and on each occasion, he applauded the fact that the practice of "handy-women" was "outlawed" (3). The choice of the word "outlaw" to describe traditional midwifery practices by the minister for health suggests a lack of appreciation for the skills and tacit knowledge of traditional midwives, often called *Bean Ghlúine* (midwife) or *Bean Feasa* (wise woman) in the Irish language. It also suggests that he considers such traditional midwifery practices to have been dangerous (Breathnach).

However, it was the places/sites that were chosen to host the conferences that I would like to consider for a moment. Both places are historically linked with women's and children's bodies through memories and through their associations. As cultural geographer and ethnographer Karen Till points out, "Central to the ways that people create meaning about themselves and their pasts is how they expect places to work emotionally, socially, culturally, and politically" (Till, *The New Berlin* 11). In light of Till's work, how then does the Rotunda Hospital work emotionally, socially, culturally, and politically? The Rotunda Hospital was the first purpose-built teaching maternity hospital in the world (A. Browne; Curran; Harrison). From its inception in the mid-eighteenth century, this hospital set the tone for all subsequent maternity hospitals both in Ireland and abroad. Despite the breadth of political changes

that occurred in Ireland's history since the hospital was created, it has persistently used its institutional authority to cultivate an obstetrically driven maternity system. Harris stated that for him that "It is only fitting that—the Rotunda—as the first lying-in hospital in the world ... should still lead out on innovations to improve health and outcomes for mothers and babies (2).

Till's explorations of memory, place, and public space reveals a complex reading of the power dynamics at play in public spaces. The minister's speech belies the complex history of power that is rooted in the very fabric of the Rotunda Hospital building itself (Till, "Wounded Cities" 3-13). Urban policy analyst and psychiatrist Mandy Fullilove uses the term "root shock" to explore the emotional implications of being forced to move and the erasure of places to people's "emotional ecosystem" (qtd. in Till, "Wounded Cities" 7).

The role of midwifery within the current maternity system in Ireland has been uprooted from local communities and now largely takes place in institutional settings, which is similar to the experience of pregnant women. As I gather the birth stories from women of different ages and who live in different places in County Clare, themes are beginning to emerge. One of them is "root shock," as described by Fullilove. The displacement that women experience during labour and in childbirth often echoes the emphasis of time over place that pervades the current obstetrically dominated maternity system in Ireland.

Women are uprooted during pregnancy and birth, but we also need to uproot "space," as Doreen Massey puts it, and move it from where it is "embedded (statis; closure; representation) and ... settle it among another set of ideas (heterogeneity; relationality) ... where it releases a more challenging political landscape" (13).

The politics of being uprooted must also consider the distance that women are expected to travel to give birth. Geographically, Ireland is a small country (e.g. Canada is 140 times larger than Ireland, and the province of Ontario, Canada, is fifteen times larger than Ireland); therefore, it can appear reasonable to ask women to travel one or two hours while in labour. However, because of such policies as AML, the tension between time and distance is crucial when in labour. Many of the women I interviewed described the anxiety of trying to time their arrival at the hospital so that they could labour without intervention. They were fearful that if their labour did not progress at the recommended rate, determined by the hospital's AML policy, they would be induced. They, therefore, felt under pressure to time their arrival at the hospital, which added considerably to their anxiety during pregnancy. A detailed analysis of these experiences is central to this PhD research project, which will be published in due course.

Conclusion

“Given that colonialism works not only by violence against the community whose land it occupies, but also by seeking to erase the traces of a native culture, the reassertion of the primacy of everyday values takes on a defiant cast.”

—Kiberd (3)

Tracing the history of the maternity services in postcolonial Ireland highlights a growing disregard of the significance of place during pregnancy, particularly at the time of birth. Between the 1930s and 1980s, Ireland effectively erased traditional midwifery practices and largely removed midwifery care from local communities; instead, an enforced dependence on an obstetrically driven maternity service developed.

The uprooting of the everyday event of childbirth from local communities raises many questions about Irish people’s relationship with place and also with authority. The authorial voice of the obstetrician dominates debates surrounding maternity services and reinforces the institutional control over women’s birthing bodies in Ireland. However, the tacit acceptance of this system by the vast majority of people highlights a complex relationship with the intersection of authority, birth, and place.

I contend that the erasure of traditional midwifery has contributed significantly to the rupture of the event of birth from birthplace in the Irish context. The disappearance of midwives whose tacit knowledge rooted them within the community is a great loss.

Yet midwifery has survived in other colonized countries, such as Australia and Canada (Olson and Couchie). When one considers the incredible work being undertaken to draw attention to the “birth evacuation policy” used to force Indigenous pregnant women in Canada to leave their home place to give birth in maternity hospitals often far from their homes, questions about the dominance of obstetric and medical models of maternity care are raised (Neufeld). Nevertheless, it is heartening to think that such midwifery and birth practices still exist among many communities and that work is being undertaken to find ways to support them.

In Ireland, a form of internalized colonization has been an important aspect of the development of the current relationship with childbirth. The valuing of the everyday event of childbirth has been hampered by policy changes that led to the erasure of traditional midwifery practices (O’Cruaíoch; Breathnach). The centralization of hospital births, which led to the drastic reduction of maternity units in the country, added a layer of anxiety for women and their families, who now have to travel longer distances to access maternity services; however, conversely, this has also reinforced a reliance on the hospital system.

It is time to reinstate the importance of place in birth and in maternity care. In her work, Till identifies the need for a “place-based ethics of care” (“Wounded Cities” 8). It is my firm hope that as this research grows and deepens, it will provide the opportunity to consider what a “place-based ethics of care” for birthing women in the West of Ireland could be. By focusing on the role that birthplace has played in the politics of birth in postcolonial Ireland, this historical overview contributes to a reimagining of the entanglements between place and birth. Working closely with feminist ecocritical thinkers and activists, this research seeks to reroot our interrelationships with childbirth and birthplace.

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